UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**EMSAM** (selegiline transdermal)

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

**All information to be legible, complete and correct or form will be returned**

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## FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

## CRITERIA:

- **Physician** documentation from charted progress notes of failure with minimum of three other antidepressants which may include MAOI
- Previous intolerance to oral trial of MAOI
- No concurrent antidepressant therapy

## AUTHORIZATION:

1 year

## RE-AUTHORIZATION:

Telephone request from doctor's office or pharmacy